Missouri Department of Transportation & Missouri State Highway Patrol

MEDICAL AND LIFE INSURANCE PLAN

1320 Creek Trail Drive
PO Box 270
Jefferson City, MO 65102

Toll free 877-863-9406
Voice 573-526-0138
Fax 573-522-1482

August 15, 2006

Subject: Supplement to the Plan Document for the Medicare Approved Prescription Drug Plan

Dear MoDOT/MSHP Medicare Part D Prescription Drug Program Participant(s):

The enclosed "Supplement to the Plan Document for the Medicare Approved Prescription Drug Plan" provides you with updates regarding the Medicare standard processes. This is an update to inform you of Medicare processes only. At this time, no changes are being made to your benefit plan design.

Please help us keep your membership record up-to-date by contacting Employee Benefits right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, contact the Employees Benefit's staff if you answer yes to the following Coordination of Benefit survey question:

1. Do you have other benefits that provide coverage for prescription drugs (i.e. Medigap, other employer coverage, etc.)
2. If yes, please provide the following from your ID card:
    a. Name of the group providing coverage
    b. Type of coverage
    c. Group #
    d. RxBIN
    e. Member ID
    f. Effective date of coverage

If you have any questions, please feel free to contact the Employee Benefits staff at 1-877-863-9406.

Sincerely,

Jeff Padgett
Manager, Employee Benefits

MISSOURI DEPARTMENT OF TRANSPORTATION
AND
MISSOURI STATE HIGHWAY PATROL
MEDICAL AND LIFE INSURANCE PLAN

SUPPLEMENT TO THE PLAN DOCUMENT FOR THE MEDICARE APPROVED PRESCRIPTION DRUG PLAN

January 1, 2006
www.modot.mo.gov/newsandinfo/benefits.htm

Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (sponsored by the Missouri Highways and Transportation Commission) with a Medicare Approved Prescription Drug Plan

Supplement to the Plan Document for Medicare Beneficiaries

January 1 – December 31, 2006

This document is the supplement to the Summary Plan Description (SPD) that gives the details about the Medicare Prescription Drug Plan.

This document is also available on the MoDOT/MSHP Employee Benefits website: www.modot.mo.gov/newsandinfo/benefits.htm.

MoDOT/MSHP is a Medicare Prescription Drug Plan. Throughout the remainder of this Evidence of Coverage, we refer to MoDOT as "Plan."

Useful Benefit Contact Information:

For Prescription Drug Questions:

PharmaCare – 24 hours a day 7 days a week

Customer Service: 1-800-311-0543

TYY: 1-800-311-0533

Web site: www.pharmacare.com

For information regarding the MoDOT/MSHP Medicare Prescription Drug Plan, contact Employee Benefits or the insurance representative at your district, division or troop assignment as follows:

Employee Benefits Contacts -

Toll-free 1-877-863-9406

Senior Benefits Specialist .....(573) 751-5704

Senior Benefits Specialist .....(573) 751-2861

Senior Benefits Specialist .....(573) 522-8121

MoDOT Districts: Contact your district insurance representative.

District 1 - St. Joseph.....(816) 387-2405

District 2 - Macon.....(660) 385-8252

District 3 - Hannibal .....(573) 248-2456

District 4- Kansas City (816) 622-6305

District 5 - Jefferson City.....(573) 526-5139

District 6 - Chesterfield.....(314) 340-4216

District 7 - Joplin .....(417) 629-3303

District 8 - Springfield .....(417) 895-7614

District 9 - Willow Springs .....(417) 469-6222

District 10 - Sikeston .....(573) 472-5368

MSHP Contact – Contact the insurance representative:

GHQ – Jefferson City ..... (573) 526-6136 or (573) 526-6356

MSHP Troops: Contact your troop insurance representative.

Troop A - Lee's Summit.....(816) 622-0800, ext. 242

Troop B - Macon.....(660) 385-2132, ext. 220

Troop C - St. Louis..... (314) 340-4059

Troop D - Springfield .....(417) 895-6767, ext. 228

Troop E - Poplar Bluff .....(573) 840-9500, ext. 219

Troop F - Jefferson City.....(573) 526-6329, ext. 221

Troop G - Willow Springs .....(417) 469-3121, ext. 226

Troop H - St. Joseph.....(816) 387-2345, ext. 220

Troop I - Rolla..... (573) 368-2345

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Medicare Part D Prescription Drug Plan

1.01 How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. "CMS" stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).

Here are ways to get help and information about Medicare from CMS:

MEDICARE

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free. Or you can visit the Medicare website at www.medicare.gov.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP)

SHIPs are organizations paid by the Federal government to give free health insurance information and help to people with Medicare. Your state SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies. **You can also find the Web site for your local SHIP at www.medicare.gov.**

QUALITY IMPROVEMENT ORGANIZATION (QIO)

The QIO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state [or territory]. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in the QIO review written quality of care complaints made by Medicare patients. The contact for the QIO in Missouri is Primaris, and their contact information is 573-817-8300, or www.primaris.org.

MEDICAID

Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your local Medicaid office.

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration provides economic protection such as retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits you can call the Social Security Administration at

1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

RAILROAD RETIREMENT BOARD

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 312-751-4701. You can also visit www.rrb.gov.

1.02 *What is a Part D Plan?*

Your Part D Plan is offered by MoDOT/MSHP, and it is a Medicare Approved prescription Drug Plan. Now that you are enrolled in our Plan, you are getting your Medicare prescription drug coverage through MoDOT/MSHP. This supplement to the SPD explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare prescription drug coverage

Your prescription drug coverage has not changed. As a member, all you have to do is continue to pay your monthly premium and pay applicable deductibles, co-pays, and co-insurances. If you have limited income and resources, you may get extra help from Medicare to pay your premium, deductible, co-payments, and co-insurances so that you get your prescription drugs for little or no cost.

Help us keep your membership record up-to-date

Please help us keep your membership record up-to-date by letting Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in prescription drug coverage you have from other sources, such as from Medicaid or from your current or former employer, or your spouse's current or former employer. In addition, you should tell Customer Service about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

Use your Plan membership card instead of your red, white, and blue Medicare card

Even though MoDOT/MSHP is a Medicare Plan, please continue to use your MoDOT/MSHP membership card and not your red, white, and blue Medicare card for prescription claims

1.03 Using plan pharmacies to get your prescription drugs covered by us

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

A ***network pharmacy*** is a pharmacy that is contracted with our Plan to provide discounted products and services. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost

by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

To find a network pharmacy close to you, you can request information from PharmaCare's Customer Service. Because network pharmacies can change, PharmaCare's Customer Service can give you the most up-to-date information about current network pharmacies. In addition, you can find this information on our Web site.

You can also use our Plan's mail order service to fill prescriptions for any covered drug. You are not required to use our mail order services to get an extended supply of medications. You can also get an extended supply through retail network pharmacies.

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances, such as an emergency, when a network pharmacy is not available. Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription.

Specialty pharmacies

Home infusion pharmacies

Plan will cover home infusion therapy if:

- Your prescription drug is covered,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your infused drug(s) from a Plan network pharmacy.

For more information, please contact Customer Service.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term care pharmacy that contracts directly with the long-term care facility. Please contact Customer Service to find out if your long term care pharmacy is part of our network.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through Plan's pharmacy network. For more information, please contact Customer Service.

Some vaccines and drugs may be administered in your doctor's office

We cover vaccines that are medically necessary and are covered by our Plan but are not already covered by Medicare Part B. In addition, we cover some drugs that may be administered in your doctor's office.

1.04 Extra Help with Drug Plan Costs for People with Limited Income and Resources

If you are Medicare eligible and have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your drug plan's monthly premium, yearly deductible, and prescription co-payments and coinsurances.

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: Amounts shown above are for 2006. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call MoDOT/MSHP Customer Service to find out what the income limits are.

Some people automatically qualify for extra help and do not have to apply for it. If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid?
- Do you get Supplemental Security Income?

Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

1.05 Monthly Premium

Please Note: *If you are receiving extra help with paying for your drug coverage, the premium amount that you pay will not be listed below.*

MoDOT/MSHP 2006 MEDICAL INSURANCE PREMIUMS

EFFECTIVE JANUARY 1, 2006

Rate Category	Plan 1 - HealthLink PPO Plan Available Statewide		
	Premium	**Employer Share**	**Subscribers Cost**
MEDICARE MEMBERS			
Retiree - Medicare Subscriber Only	$211.00	$128.00	$83.00
Retiree - Medicare Sub./Non-Med. Spouse	$517.00	$217.00	$300.00
Retiree - Medicare Sub./Medicare Spouse	$422.00	$201.00	$221.00
Retiree - Subscriber/Family w/ 1 Medicare	$836.00	$390.00	$446.00
Retiree - Subscriber/Family w/ 2+ Medicare	$743.00	$390.00	$353.00
Retiree - Medicare Subscriber/Child	$517.00	$242.00	$275.00
Retiree - Medicare Subscriber/Med. Child	$422.00	$205.00	$217.00
Retiree - Medicare Subscriber/2 Children	$601.00	$252.00	$349.00
Survivor - Medicare Subscriber Only	$211.00	$128.00	$83.00
Survivor - Subscriber/Family w/ 1 Medicare	$836.00	$390.00	$446.00
Survivor - Subscriber/Family w/ 2+ Medicare	$743.00	$390.00	$353.00
Survivor - Medicare Subscriber/Child	$517.00	$242.00	$275.00
Survivor - Medicare Subscriber/Med. Child	$422.00	$205.00	$217.00
Survivor - Medicare Subscriber/2 Children	$601.00	$252.00	$349.00
LTD - Medicare Subscriber Only	$211.00	$128.00	$83.00
LTD - Medicare Sub./Non-Medicare Spouse	$517.00	$217.00	$300.00
LTD - Medicare Subsriber/Medicare Spouse	$422.00	$201.00	$221.00
LTD - Subscriber/Family w/ 1 Medicare	$836.00	$390.00	$446.00
LTD - Subscriber/Family w/ 2+ Medicare	$743.00	$390.00	$353.00
LTD - Medicare Subscriber/Child	$517.00	$242.00	$275.00
LTD - Medicare Subscriber/2 Children	$601.00	$252.00	$349.00
WRD - Medicare Subscriber Only	$211.00	$211.00	$0.00
WRD - Medicare Sub./Non-Medicare Spouse	$517.00	$423.00	$94.00
WRD - Medicare Sub./Medicare Spouse	$422.00	$362.00	$60.00
WRD - Subscriber/Family w/ 1 Medicare	$836.00	$700.00	$136.00
WRD - Subscriber/Family w/ 2+ Medicare	$743.00	$622.00	$121.00
WRD - Medicare Subscriber/Child	$517.00	$477.00	$40.00
WRD - Medicare Subscriber/2 Children	$601.00	$499.00	$102.00

Vested - Medicare Subscriber Only	$211.00	$0.00	$211.00
Vested - Subscriber/Family w/ 1 Medicare	$836.00	$0.00	$836.00
Vested - Subscriber/Family w/ 2+ Medicare	$743.00	$0.00	$743.00
Vested - Medicare Sub./Medicare Spouse	$422.00	$0.00	$422.00
Vested - Medicare Sub./Non-Med. Spouse	$517.00	$0.00	$517.00
Vested - Medicare Subscriber/Child	$517.00	$0.00	$517.00
Vested - Medicare Subscriber/2 Children	$601.00	$0.00	$601.00

OTHER PLAN CATEGORIES

LTD - Non-Med. Sub./Medicare Child	$517.00	$252.00	$265.00
LTD- Non-Med. Sub./Medicare Spouse	$517.00	$247.00	$270.00
Survivor - Non-Med. Sub./Medicare Child	$517.00	$252.00	$265.00
Vested - Non-Med Sub./Medicare Spouse	$517.00	$0.00	$517.00

Sub. = Subscriber

Non-Med. = Non-Medicare

LTD = Long Term Disability

WRD = Work Related Disability

If you have any questions about your plan premiums or the different ways to pay them, please call our MoDOT/MSHP Customer Service numbers listed on the cover and in the Introduction section.

Failure to pay your past-due plan premiums within the grace period will result in your disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period.

To be a member of our Plan, you must either be entitled to Medicare Part A or enrolled in Medicare Part B and live in our service area. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of this plan.

You will have to pay a late enrollment penalty in addition to your monthly plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *creditable* coverage for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the late enrollment penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. If you get extra help, your penalty amount may be lower than it is for those who don't qualify. In addition, you may only have to pay the penalty for a maximum of 60 months.

1.06 Prescription Drug Coverage

This section describes your prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

Drugs Covered by the Plan

Your drug coverage has not changed.

Under the Plan, standard covered drugs include:

- Federal Legend Drugs which is defined as a drug product which bears the legend, "Caution: Federal Law prohibits dispensing without a prescription."
- Compound Medication which is defined as an extemporaneously prepared combination of two or more drug products containing at least one federal legend drug in a therapeutic amount. See also Standard Excluded Drugs.

Under the Plan, standard excluded drugs include (some exceptions apply):

- OTC products or over-the counter equivalents and state restricted drugs
- Therapeutic devices or appliances
- Immunization agents, vaccines, diagnostic agents, general anesthetics
- Implantable time-released medications
- Experimental or investigational drugs; or drugs prescribed for experimental (non-FDA approved/unlabeled) indications
- Agents when used for cosmetics purposes
- Nutritional supplements
- Agents when used for weight loss / weight gain
- Agents when used to treat infertility
- Extemporaneously prepared combinations of raw bulk chemical ingredients or combinations of federal legend drugs in a non-FDA approved dosage form

If you have questions about whether your prescription is covered under the plan, please contact PharmaCare customer service.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. Examples of utilization management tools are described below:

Prior Authorization: We require you to get prior authorization for certain drugs. This means that will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

Possible medication errors

Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition

- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management (MTM) programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. However, our Plan will coordinate coverage. Please contact PharmaCare customer service for information on how to submit a secondary claim.

Please see your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. If you are qualified for extra help, specific information on the level of assistance with premiums and cost sharing will be sent to you.

Drug costs for each coverage level are described below.

MoDOT/MSHP Medicare Supplement Plan Summary of Benefits

Effective January 1, 2006

Listed below is a partial outline of coverage under the MoDOT/MSHP Member Handbook. This summary should not be relied upon to fully determine coverage. See the MoDOT/MSHP Member Handbook for applicable limits and exclusions to coverage for health services. If differences exist between this summary of benefits and the handbook, the handbook governs.

	MEDICARE SUPPLEMENT PLAN Available Nationwide
Pharmacy Benefit - Available Through Participating Pharmacies Only	
Individual Deductible per CY	$75
Generic	30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment.
Brand	**If a generic is available:** 30% coinsurance of brand drug's cost plus the difference in cost between the brand and generic after the CY deductible at retail and mail order pharmacy with $5 minimum copayment. **If no generic is available:** 30% coinsurance after the CY deductible r at retail and mail order pharmacy with $5 minimum copayment. **If brand is medically necessary and approved by PharmaCare:** 30% coinsurance after the CY deductible at retail and mail order pharmacy with $5 minimum copayment.
Catastrophic Coverage	Once you reach $3,600 of out-of-pocket expense* (deductible + coinsurance + penalties) your cost sharing will be reduced to the greater of 5% coinsurance or $2 copayment for Generics and $5 copayment for Brands *Payments made by group health plans, insurance plans, government

	funded health programs (e.g. TRICARE the Indian Health Service); and third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation) do not accumulate towards your out of pocket expenses.

Explanation of Benefits

The Explanation of Benefits (EOB) is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs. This will help you track your drug expenses. An EOB is also available upon request. To get a copy, please contact PharmaCare Customer Service.

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network and the drug is not covered by Medicare Part B coverage. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process. When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan.

1.07 If You Have Other Prescription Drug Coverage

We will send you a COB Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call customer service to update your membership records. NEGLECTING TO INFORM YOUR PLAN OF OTHER COVERAGE COULD RESULT IN LOSS OF MEDICARE BENEFITS.

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your premiums, deductibles, and co-payments. Please contact your SPAP to determine what benefits are available to you.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy **that includes coverage for prescription drugs**, you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove

the prescription drug coverage portion of your policy and adjust your premium. In addition, under certain circumstances, you may be able to purchase a different Medigap policy from the same company. Your Medigap issuer cannot charge you more based on any past or present health problems.

In the fall of 2005, your Medigap issuer sent a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did not get this letter, please contact your Medigap issuer.

If you are a member of an employer or retiree group other than MoDOT/MSHP

If you currently have prescription drug coverage through another employer or retiree group, please contact your MoDOT/MSHP benefits department to determine how your current prescription drug coverage will work with this Plan.

1.08 Appeals and Grievances: what to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call the appropriate Customer Service number listed on the cover. Generally PharmaCare handles questions, concerns or problems related to the drug benefit & coverage determinations. The Plan Administration unit handles other questions, concerns, or problems related to enrollment, billing, address changes & ID card replacements, etc.

This document describes the process for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when someone makes a complaint. You cannot be disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. An explanation of these complaint types as well as how to file them follows below.

Grievances

A **grievance** is any complaint that does not involve whether a drug is covered or how much you have to pay for a drug. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. Grievances are handled by the Plan Customer Service Department.

If you have a grievance, we encourage you to first call PharmaCare's Customer Service at the number listed on the first page. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this Processing of Expedited and Standard Grievances for Medicare Part D. Within this process, your grievance will be handled by Plan in accordance with CMS guidelines. The Plan Employee Benefits Contacts are available, Monday–Friday, from 8:00 a.m. to 4:00 p.m. CST. During non-business hours, you may leave a message and your call will be returned on the next business day. You may submit your grievance to Plan by mail, phone or fax: mail to MODOT Attn: Employee Benefits, P.O. Box 270, Jefferson City, MO 65102 phone by calling 1-877-863-9406 or fax to (573) 522-1482. You will be notified of the

grievance ruling within 30 days of the date the grievance was filed. Exceptions to the 30 day ruling timeframe may be made in accordance with CMS guidelines to accommodate extensions and expedited issues. Expedited grievances or grievances involving a refusal to grant an expedited coverage determination or expedited re-determination and you have not yet purchased or received the drug in dispute, the grievance ruling will be communicated to you within 24 hours of receipt.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the **Quality Improvement Organization (QIO)**. Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare prescription drug plan under the grievance process or by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Part D plan's grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See page 3 for more information about how to file a quality of care complaint with the QIO.

Coverage Determinations

Every time you receive a drug, a **coverage determination** is made as to whether the Plan will pay for the drug and what your share of the cost is for the drug. When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits of our Plan apply to your specific situation. This document and any amendments you may receive describe the Part D prescription drug benefits covered by our Plan, including any limitations that may apply to these benefits.

The coverage determination made by our Plan is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you have the right to request an exception. If you believe you need a drug that is not covered by our Plan you should contact our Plan at the PharmaCare Customer Service Department and ask us for an exception. If you request an exception, your doctor must provide a statement to support your request. With our decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can **"appeal"** our decision. (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see below). You cannot request an appeal if we have not issued a coverage determination.

You can ask us for a coverage determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your *appointed representative.* You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to

act as your appointed representative. You can call PharmaCare Customer Service to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you have not yet received your drugs and you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

To ask for a standard or fast decision, you, your doctor, or your appointed representative should refer to the PharmaCare Customer Service numbers listed at the beginning of the document. Your prescribing physicians may contact **PharmaCare's Medicare Clinical PA Department at (800) 311-0594 Monday-Friday 8am-5pm EST. The hearing impaired may call the TTY/TDD line at (800) 311-0607.** If you are requesting a fast decision, be sure to ask for a "fast," "expedited," or "24-hour" review.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard timeframe.

Appeals

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug. PharmaCare's Customer Service Department will handle appeals.

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request, you can appeal. A coverage determination, may be appealed if you disagree with our decision.

There are five levels to the appeals process. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

You make your request for coverage or payment of a Part D prescription drug directly to PharmaCare. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast appeal are the same as those described for a standard or fast coverage determination.

MEDICARE APPEAL PROCESS

Appeal Level	Who Can File the Appeal	Who Reviews the Appeal	How to Request the Appeal	How Soon Must You File Your Appeal?	When Will You Receive a Decision	If the Appeal is in Your Favor
Level 1	You, your doctor, an attorney or your appointed representative	PharmaCare	In writing Telephone Fax	Within 60 calendar days from the date included on the notice of our coverage determination	Standard - 7 Days Fast – 72 Hours	Standard (and you have received the drug) - payment made within 30 days Standard (and you have not received the drug) - drug coverage within 7 days Fast (and you have not received the drug) - drug coverage within 72 hours
Level 2	You or your appointed representative	Independent Review Organization	In writing	Within 60 calendar days from the decision of Level 1 Appeal	Standard - 7 Days Fast – 72 Hours	Standard (and you have not received the drug) - payment made within 30 days Standard (and you have not received the drug) - drug coverage within 72 hours Fast (and you have not received the drug) - drug coverage within 24 hours

Level 3*	You or your appointed representative	Administrative Law Judge	In writing	Within 60 calendar days from the decision of Level 2 Appeal	Discretion of the Judge	Standard (and you have not received the drug) - payment made within 30 days Standard (and you have not received the drug) - drug coverage within 72 hours Fast (and you have not received the drug) - drug coverage within 24 hours
Level 4*	You or your appointed representative	Medicare Appeals Council	Described in Level 3 decision letter	Case specific	Discretion of the Council	Standard (and you have not received the drug) - payment made within 30 days Standard (and you have not received the drug) - drug coverage within 72 hours Fast (and you have not received the drug) - drug coverage within 24 hours
Level 5*	You or your appointed representative	Federal Court Judge	Described in written notice by Council	Case specific	Discretion of the Federal judiciary	Standard (and you have not received the drug) - payment made within 30 days Standard (and you have not received the drug) - drug coverage within 72 hours Fast (and you have not received the drug) - drug coverage within 24 hours

* Restricted by value of benefit in appeal.

For more information about the appeal process or help requesting an appeal, please contact PharmaCare Customer Service for assistance.

1.09 Disenrollment as a Member of this Plan

"Disenrollment" from our Plan means ending your membership with us. Disenrollment can be voluntary (your own choice) or, in limited circumstances, involuntary (not your own choice). Our Plan cannot ask you to leave because of your health.

Disenrollment is further explained in the **Missouri Department of Transportation (MoDOT) and Missouri State Highway Patrol (MSHP) Medical and Life Insurance Plan (sponsored by the Missouri Highways and Transportation Commission) SPD.** If you have any questions regarding disenrollment, please contact Employee Benefits.

1.10 Your Rights and Responsibilities as a Member of this Plan

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1800-368-1019 or TTY/TDD 1-800-537-7697, or call the Office for Civil Rights in your area. If you need help with communication, such as help from a language interpreter, please call our Customer Service numbers listed on the cover.

Your right to the privacy of your medical records and personal health information

There are Federal and State laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call our Customer Service numbers listed on the cover.

Your right to get your prescriptions filled within a reasonable period of time

You have the right to go to any network pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed *against* us in the past. To get this information, call our Customer Service numbers listed on the cover.

Your right to get information about your drug coverage and costs

This document tells you what you have to pay for prescription drugs as a member of Plan. If you need more information, please call our Customer Service numbers listed on the cover. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision.

Your right to get information about our Plan and our network pharmacies

You have the right to get information from us about the Plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Customer Service at the phone number listed on the cover.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call our Customer Service numbers listed on the cover and in the Introduction section. You can also get free help and information from State Health Insurance Assistance Program, or SHIP. In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Customer Service numbers listed on the cover or your State Health Insurance Assistance Program.

What are your responsibilities as a member of our Plan?

Along with the rights you have as a member of our Plan, you also have some responsibilities. Your responsibilities include the following:

Become familiar with your coverage and the rules you must follow to get care as a member.

Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.

Pay your plan premiums and any co-payments you may owe for the covered drugs you get.

Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call our Customer Service numbers listed on the cover.

1.11 Legal Notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other Federal laws may apply and, under certain situations, the laws of your state {or territory} may also apply.

Notice about nondiscrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like us, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

NOTES PAGE